

STATE OF MICHIGAN
DEPARTMENT OF LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 92546-001

v

Humana Insurance Company
Respondent

Issued and entered
This 18th day of September 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On August 11, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of the Office of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the information received the Commissioner accepted the request on August 18, 2008.

The issue here can be decided by an analysis of the terms of the Petitioner's health care coverage. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner has group health care coverage from Humana. His benefits are defined in the certificate of insurance (the certificate) issued by Humana.

On October 12, 2007, the Petitioner had a physician office visit and laboratory services. Humana applied the charges for the laboratory services to the Petitioner's network deductible and

coinsurance, leaving the Petitioner responsible for an out-of-pocket expense of \$517.19.

The Petitioner appealed Humana's decision and exhausted Humana's internal grievance process. Humana maintained its denial and sent a final adverse determination dated May 19, 2008.

III ISSUE

Did Humana correctly process the Petitioner's claim for his lab services?

IV ANALYSIS

Petitioner's Argument

The Petitioner does not think that the charges for the laboratory tests done at the same time as an office visit should be applied to the \$500.00 network deductible. He cites a provision in the "Humana PPO Summary of Benefits" that says diagnostic laboratory and radiology services that are included with an office visit are 100% payable, with no mention of the deductible. He says he was at his doctor's office, not at a hospital, and cannot understand why the tests were processed as an outpatient hospital charge.

He wants the charges for the laboratory services included as part of his office visit, which only had a \$25.00 copayment.

Humana Insurance Company's Argument

Humana explained its position in its final adverse determination:

This decision was based on your Benefit Plan Document which states diagnostic laboratory services when performed in the office and billed by the health care provider is covered at 100 percent. Participating hospital outpatient services will be covered at 80 percent after your \$500.00 participating provider deductible has been met.

According to the claim Humana received, the laboratory services were provided in the outpatient department of the XXXXX, a network hospital. The certificate says that hospital outpatient non-surgical services performed in a hospital's outpatient department are "80% benefit payable after network provider deductible." Humana says that diagnostic laboratory services are

only covered at 100% when performed by the physician in the physician's office.

At the time the claim was processed the \$500.00 network deductible was not met. Therefore, Humana applied the first \$500.00 in charges to the network deductible.

Humana says it has no control over where physicians send members for laboratory services or how those providers bill for their services. Benefit coverage is based on (but not limited to), the place of service, the type of service performed, and the type of provider utilized. In order to maintain consistency in claims processing, claims are processed and reimbursed based on the information submitted with the claim. Further, Humana says there is no provision in the certificate that allows the physician office level of benefits when the services are performed in the outpatient department of a hospital.

Humana believes that it correctly processed the Petitioner's laboratory claims.

Commissioner's Review

The Petitioner says he was at a doctor's office visit, not at a hospital, and therefore he does not understand why his laboratory tests were billed as an outpatient hospital charge. Nevertheless, from the records in the file it is apparent that the tests were performed and billed as an outpatient service by XXXXX, a network hospital.

The provision in the certificate that the Petitioner cites that says diagnostic laboratory and radiology services are covered 100% (page 14) applies only when those services are performed and billed as part of a physician office visit. The laboratory tests here were not billed by the Petitioner's physician – they were billed by the XXXXX Hospital as shown on the claims detail forms.

The certificate is clear (page 17) that hospital outpatient non-surgical services are subject to the network deductible and then paid at 80%. Since nothing in the record indicates that the \$500.00 network deductible had been satisfied, Humana was correct in applying the first \$500.00 charges for the laboratory tests to the Petitioner's deductible and then covering the claims.

**V
ORDER**

The Commissioner upholds Humana Insurance Company's final adverse determination of May 19, 2008.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.